**GEORGIA DEPARTMENT OF HUMAN RESOURCES**
**Office of Regulatory Services**
**Health Care Section**
2 Peachtree Street, N.W. Suite 33-250
Atlanta, Georgia 30303
Tel: 404.657.5550 Fax: 404.657.8934

# ESRD INCIDENT REPORTING FORM

**(Please Type Form)**

## FACILITY INFORMATION

**Name of Facility:**_____

**Facility Type:**_____ **License #:** _____

**Address:** _____

**City:**_____**State:**_____ **Zip Code:**_____

**Person Reporting Incident:**_____**Title:**_____

**Contact Person(s):**_____ **Phone Number of Contact:** _____

**Fax #:** _____ **Email Address:**_____

## Patient /Reporting Information

**Date**_____ **Time** _____ **a.m./p.m. Reported to ORS Agency**

**Date**_____ **Time** _____ **a.m./p.m. ESRD Facility Was Aware of Incident**

**Date**_____ **Time** _____ **a.m./p.m. Incident Occurred**

| _____ | _____ | _____**M/F** | _____ |
|---|---|---|---|
| **Patient Name** | **Age** | **Sex** | **Date of Birth** |

| _____ | _____ | _____ |
|---|---|---|
| **Medical Record #** | **Date of Admission** | **Date Dialysis Started** |

**Diagnosis *(all)*:** _____

_____

**Patients Current Condition:** ***(check one)*** ***[ ] Dialyzing in center [ ] In Hospital [ ] Deceased***

***Type of Incident*: *Please check appropriate boxes*.** (Attach a copy of incident report if applicable)

**[ ] Death**
**[ ] Serious Injury/malfunction of equipment**
**[ ] Exsanguination at facility**
**[ ] Use of another patient's dialyzer**
**[ ] Deviation in patient's prescription**
**[ ] Sexual/Physical assault of patients**

***Briefly describe circumstances of the incident:*** *(attach additional sheet if necessary)*

**CATEGORY OF STAFF INVOLVED IN THE INCIDENT** (check all that apply)

***[ ] Attending MD [ ] MD Resident [ ] LPN [ ] RN [ ] PA [ ] NP [ ] SW [ ] Dietician***

***[ ] Trainee (specify type)*** _____ ***[ ] PCT (specify type)*** _____

***[ ] Other (specify type)*** _____

***Immediate Corrective or Preventative Action Taken:*** (*attach additional sheet if necessary)*

_____
_____
_____
_____

**Note: If the incident involved a death, was the medical examiner notified? [ ]Yes [ ] No**
**Was an autopsy requested? [ ] Yes [ ] No**
**Name and contact number of Medical Examiner**_____

***Acknowledgement of Information Reported:***

***I swear that the information reported within this form is true and accurate and completed to the best of my knowledge.***

_____ _____ _____
***Signature of Person Completing Form*** ***Title*** ***Date Completed***

_____
***Print Name***

***For Department Use Only***

**Received in S/A Date:**_____

**Reviewed By:**_____

**Date:**_____

**Reporting time frame of 24 hours met? ( ) Yes ( ) No**

**Action Require ( ) Yes ( ) No**

**Self Report ID #:** _____ **Complaint Number:** _____

This report is required as set forth in the ESRD Rules §290-9-9-.07(c)1 through §290-9-9-.07(c)6 and must be submitted to the Department within twenty-four (24) hours or by the next regular business day from when the incident occurred, or from when the facility has reasonable cause to suspect a reportable incident §290-9-9-.07(d).